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Supreme Court, U.S.
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No.

In The
Supreme Court of the United States

LYNN JEWELL,

Petitioner

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Respondent

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a civil action brought pursuant to ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)) to recover benefits due under the terms of an employee benefit plan is properly adjudicated under the *de novo* standard as an action involving a review of a record or as a plenary proceeding?

LIST OF PARTIES

The parties to this action are all listed in the caption: The Petitioner, Lynn Jewell, was plaintiff and appellee in the courts below, and Respondent, Life Insurance Company of North America, defendant and appellant.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Tenth Circuit is reported as *Jewell v. Life Insurance Co. of North America,* 508 F.3d 1303 (10th Cir. 2007)(Reprinted at Appendix 1a-29a). The Court of Appeals reversed the ruling of the district court awarding disability benefits to the Petitioner, a participant in an employee benefit plan governed by ERISA, 29 U.S.C. § 1001 *et seq.*, which was fully insured by Respondent. The judgment of the district court was issued on June 1, 2006 and is unpublished (Appendix 30a-31a).

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act, a federal law.

The Tenth Circuit's opinion was issued on November 30, 2007. No rehearing was sought.

CONSTITUTIONAL AND STATUTORY PROVISIONS, COURT RULES INVOLVED

Title 29, United States Code, Section 1132(a) states:

> (a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary—

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

Federal Rules of Civil Procedure 1 and 2 state in relevant part:

Rule 1. Scope and Purpose of Rules.

These rules govern the procedure in the United States district courts in all suits of a civil nature whether cognizable as cases at law or in equity or in admiralty, with the exceptions stated in Rule 81...

Rule 2. One Form of Action.

There shall be one form of action to be known as "civil action."

STATEMENT OF THE CASE

1. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, "was enacted to promote the interests of employees and their beneficiaries in employee benefit plans . . . and to protect contractually-defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989).

2. ERISA requires benefit plans covered by the Act to provide internal dispute resolution procedures in order to meet the statutory mandate of providing a "full and fair review" of benefit denials. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. According to the seminal ruling on this issue, *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980), Congress' apparent intent in mandating internal claims procedures was to minimize the number of frivolous ERISA lawsuits, promote the consistent treatment of benefit claims, provide a nonadversarial dispute resolution process, and decrease the cost and time of claims settlement.

3. An employees whose benefit claim is not resolved through internal dispute resolution procedures is authorized to bring a "civil action" to "recover benefits due ... under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). That cause of action is the exclusive civil enforcement remedy available to ERISA claimants seeking to recover benefits. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

4. ERISA does not specify the standards under which a court adjudicates benefit disputes. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), the Court held that employee benefit determinations are to be evaluated under the *de novo* standard "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." The parties and both the district court and Court of Appeals concurred that the *de novo* standard applied to the adjudication of Petitioner's claim. App. 6a.

5. Although *Firestone* dealt specifically with the standard of review utilized in adjudicating ERISA benefit claims, the Court has never directly addressed the scope of the district court's adjudicatory powers irrespective of the applicable standard of review. Thus, the principal question framed by this petition is whether a civil action authorized by ERISA § 502(a)(1)(B) is a plenary proceeding governed by the Federal Rules of Civil Procedure or limited to a review of a claim record as a court would decide an administrative law claim. This case squarely presents that question.

6. Despite applying the *de novo* standard, the Court of Appeals determined it was obligated to "restrict de novo review to the administrative record compiled during the claim administration process, instead of taking new evidence, hearing witnesses, and the like." App. 6a-7a.

7. The Tenth Circuit's position is in direct conflict with *Diaz v. Prudential Insur.Co.*, 499 F.3d 640 (7th Cir. 2007), which, like the case at bar, also involved a claim for disability insurance benefits brought pursuant to 29 U.S.C. § 1132(a)(1)(B) and adjudicated under the *de novo* standard. *Diaz* held:

> The district court's task in engaging in *de novo* consideration of the decision of the plan administrator is not the same as its job in reviewing administrative determinations on the basis of the record the agency compiled under the substantial evidence rule, as it might do

> in a Social Security benefits case. See *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996). Some of the confusion in this area may be attributable to the common phrase " *de novo* review" used in connection with ERISA cases. In fact, in these cases the district courts are not *reviewing* anything; they are making an independent decision about the employee's entitlement to benefits. In the administrative arena, the court normally will be required to defer to the agency's findings of fact; when *de novo* consideration is appropriate in an ERISA case, in contrast, the court can and must come to an independent decision on both the legal and factual issues that form the basis of the claim.

499 F.3d at 643 (emphasis in original).

8. Lynn Jewell, a former Director of National Sales for Sprint Telecommunications, developed severe headaches, dizziness, and other maladies which caused him to cease working in 1998. Sprint's disability insurer and *de facto* plan administrator, the Life Insurance Company of North America (LINA), acknowledged the severity of Jewell's impairments and paid him both short-term disability income benefits as well as long-term disability insurance benefits. Those benefits continued for two years; however, LINA ceased making payments after two years, claiming the duration of payments was limited to no more than a

two year period on account of the insurer's classification of Jewell's medical condition as falling under policy limitations applicable to mental and nervous disorders.

9. After the benefits expired, Jewell appealed to LINA seeking reinstatement, claiming he was not disabled due to a psychiatric condition. Jewell maintained that his disability was due all along to a stroke he had suffered earlier, and that the diagnosis was not made clear until additional testing had been performed.* Jewell supported his appeal with medical records and reports from a neurologist and another physician; however, LINA determined the evidence presented was insufficient and refused to reinstate the claim. A second appeal was also unsuccessful, and Jewell subsequently brought suit against LINA in the state court in Colorado, which was removed to federal court based on ERISA preemption.

10. LINA then moved for "judgment on the administrative record" whereupon Jewell moved to

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* These facts are not unique. It is not unusual that a disability due to a particular diagnosis may not be immediately established and may require extensive testing before the etiology of a disability is established. In both *Rochow v. Life Ins.Co. of North America,* 482 F.3d 860 (6th Cir. 2007) and *Woo v. Deluxe Corp.,* 144 F.3d 1157 (8th Cir. 1998), the ERISA plan administrators were found to have wrongfully denied benefits by refusing to accept a retrospective diagnosis that established an earlier onset of disability due to encephalitis (Rochow) and scleroderma (*Woo*).

supplement the record to consider additional reports from two of his treating doctors along with his own affidavit. The court granted Jewell's request, finding the materials submitted would assist the court in understanding the medical issues under consideration; and following an oral argument before the district court, judgment was granted in Jewell's favor.

11. The Court of Appeals reversed, holding the district court abused its discretion in allowing additional evidence to supplement the "administrative" record. The court determined the additional evidence was not necessary or previously unavailable and should therefore not have been considered. The case was then remanded to the district court "for *de novo* review based on the administrative record." App. 29a.

REASONS FOR ALLOWANCE OF THE WRIT

This case presents an opportunity for the Court to address a significant question that has caused confusion and conflict in the lower courts: Whether civil actions brought under ERISA are to be treated as review proceedings. As noted earlier and which will be explained in more detail below, *Jewell's* conclusion that the district court's function is to review an "administrative record" conflicts with decisions issued by the Seventh and Eleventh Circuits. *Jewell* also disregards two significant Supreme Court rulings that describe the nature of a *de novo* proceeding as plenary rather than a record review. Finally, there is no support for *Jewell's* imposition of a quasi-administrative law regime over ERISA civil actions without corresponding procedural and due process protections inherent in administrative law.

I. *The Jewell Ruling Conflicts With the ERISA Statute, Prior Rulings of the Supreme Court, and Rulings Issued By Other Courts of Appeals*

A. *Jewell* Is In Direct Conflict With Rulings Issued by Other Circuits

The conclusion that the determination of Jewell's entitlement to disability benefits is to be based on the review of an "administrative record" is in direct conflict with *Diaz v. Prudential Ins. Co.*, 499 F.3d 640, 643 (7th Cir. 2007). *Diaz* explicitly recognizes the inappropriateness of a review proceeding akin to administrative review:

> The district court's task in engaging in *de novo* consideration of the decision of the plan administrator is not the same as its job in reviewing administrative determinations on the basis of the record the agency compiled under the substantial evidence rule, as it might do in a Social Security benefits case. See *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996).

Nor is the Seventh Circuit the only Court of Appeals to reject the application of "administrative" reviews of ERISA benefit determinations, particularly with respect to cases adjudicated under the *de novo* standard. In *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989), the Eleventh Circuit similarly found:

> [A] contention that a court conducting a de novo review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a de novo review. During oral argument, American Home's counsel conceded that absent ERISA, there would be no deferential standard of review of the denial of coverage. Thus, what the Supreme Court said of a similar contention advanced in Firestone is equally applicable to this contention: "Adopting [this] reading of ERISA would require us to impose a standard of review that would afford

> less protection to employees and their beneficiaries than [they enjoyed] before ERISA was enacted.'"

Hence, the direct and profound conflict among the Circuits needs to be rectified in order to remove the misapplication of administrative law principles in ERISA litigation.

B. *Jewell* Conflicts with the Civil Action Authorized by ERISA as well as With Supreme Court Precedents

Contrary to the Tenth Circuit's determination, the *de novo* adjudication of a civil action authorized by § 502 of the Employee Retirement Income Security Act is not a proceeding to review a claim record. Congress' authorization of a "civil action...to recover benefits due ... under the terms of [a] plan" (29 U.S.C. § 1132(a)(1)(B)) entitles plan participants to a plenary court proceeding rather than a claim record review based on the principles established by *Chandler v. Roudebush,* 425 U.S. 840 (1976).

Although *Chandler* involved a claim for employment discrimination based on § 717(c) of the Civil Rights Act, 42 U.S.C. §2000e *et seq.* rather than an employee benefit dispute, its delineation between statutes that invoke review proceedings and those that trigger plenary adjudication is nonetheless instructive. *Chandler* resolved a split in the Circuits as to whether federal employees' civil rights claims were review proceedings by holding

that federal employees seeking redress of civil rights violations were entitled to discovery and a trial, explaining: "Nothing in the legislative history indicates that the federal-sector "civil action" was to have this chameleon-like character, providing fragmentary de novo consideration of discrimination claims where "appropriate," ibid., and otherwise providing record review." 425 U.S. at 861. The Court added,

> In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." Ibid. E. g., 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21 (c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371 (f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare).

425 U.S. at 862 n.37. ERISA makes no reference whatsoever to substantial evidence or other terms of art typically associated with administrative law that would signal an intent to authorize a review proceeding rather than a trial. Hence, the imposition of a review proceeding is entirely misplaced.

That conclusion is further supported by *United States v. First City National Bank*, 386 U.S. 361 (1967). *First City* involved a suit brought by the United States challenging a bank merger as anti-competitive. The Court was called upon to construe the requirements of the Bank Merger Act of 1966, 12 U.S.C. § 1828(c)(7)(A). and § 1828(c)(7)(B) which specified the standards to be applied by a court in a judicial proceeding challenging a bank merger. Section 1828(c)(7)(A) stated, "In any such action [to challenge a bank merger], the court shall review *de novo* the issues presented." In interpreting that provision to describe the type of court proceeding that would be conducted, the Court explained:

> It is argued that the use of the word "review" rather than "trial" indicates a more limited scope to judicial action. The words "review" and "trial" might conceivably be used interchangeably. The critical words seem to us to be "*de novo*" and "issues presented." They mean to us that the court should make an independent determination of the issues.

386 U.S. at 368. The Court then addressed the inappropriateness of an administrative law paradigm, finding its use under the *de novo* standard would require the Court to "assume the Congress made a revolutionary innovation by making administrative action well nigh conclusive, even though no hearing had been held and no record in the customary sense created." *Id.*

Thus, absent specific statutory direction in ERISA's language or its legislative history, the imposition of an administrative review is not an appropriate regime for ERISA practice. Indeed, in the Conference Report issued in conjunction with ERISA's passage, Congress explained that ERISA civil actions "are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." H.R. Conf. Rep. 93-1280, 93d Cong., 2d Sess. 327 (1974). According to *Textile Workers Union v. Lincoln Mills,* 353 U.S. 448, 456 (1957), Section 301 (29 U.S.C. §185) requires the federal courts to "fashion from the policy of our national labor laws" a federal common law governing the interpretation of collective bargaining agreements which has been held to require plenary proceedings that even encompass trials before juries. *See, Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry,* 494 U.S. 558 (1990).

Although the Court has never ruled on this precise issue, *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 112 (1989) points out that prior to ERISA's passage, claims such as Jewell's were "governed by principles of contract law." *Firestone*

also clearly established that ERISA's passage was never intended to afford "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 114 (1989). Thus, historically, disputes over entitlement to disability benefits provided as employee benefits were resolved through plenary court proceedings. *See, e.g., Cox v. Washington Natl. Insur.Co.,* 520 S.W.2d 76 (Ct.App.Mo. 1974)(employer sponsored disability benefit claim accorded plenary civil procedure); *Antram v. Stuyvesant Life Insur.Co.,* 287 So.2d 837 (Ala. 1973)(same).

Moreover, even under the common law of trusts, which underpins much of ERISA according to *Firestone,* plenary proceedings have historically been the norm. *See, e.g., Barnett v. Ross,* 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct of alleged trustee); *Phelps Dodge Corp. v. Brown,* 112 Ariz. 179, 540 P.2d 651 (1975)(jury trial conducted); *Matthews v. Swift & Co.,* 465 F.2d 814 (5th Cir. 1972)(plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review). Consequently, there were no grounds whatsoever for the Tenth Circuit to have ordered Jewell's claim for benefits to be conducted as a review proceeding.

II. *Jewell Imposes a Quasi-Administrative Law Regime But Denies the Due Process Protections of Administrative Claim Determinations*

Contrary to the framework established by the Federal Rules of Civil Procedure for the adjudication of all civil actions (Rule 1); and Rule 2's statement that there is but one form of civil action, ERISA litigation has been transformed into a quasi-administrative law regime conducted outside the bounds of the the Federal Rules of Civil Procedure. Beginning with *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003 (4th Cir. 1985), the metamorphosis of ERISA litigation continued when the Sixth Circuit issued *Perry v. Simplicity Engineering*, 900 F.2d 963, 967 (6th Cir. 1990) and *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609, 618 (6th Cir. 1998), which pronounced:

> We are satisfied that a district court should not adjudicate an ERISA action as if it were conducting a standard bench trial under Rule 52. Such a proceeding would inevitably lead to the introduction of testimonial and/or other evidence that the administrator had no opportunity to consider. A district court's evaluation of such evidence would contravene Perry's mandate confining the district court's de novo review to the evidence contained in the administrative record.

Hence, the institution of a review proceeding in place of a trial contravenes the requirement of

Federal Rule of Civil Procedure 43(a): "At trial, the witnesses' testimony must be taken in open court unless a federal statute, the Federal Rules of Evidence, these rules, or other rules adopted by the Supreme Court provide otherwise." Since neither ERISA, the Federal Rules of Evidence, nor the Federal Rules of Civil Procedure make an exception for civil actions authorized by ERISA (29 U.S.C. § 1132(a)), the importation of administrative law standards is unjustified.

Nor is the stated justification for the utilization of administrative law principles a valid rationale. A frequently stated justification claims that ERISA was enacted to provide "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously," (S. Rep. No. 93-383, at 1179 (1973) reprinted in 1974 U.S.C.C.A.N. 4639, 5000). *See, Perry,* 900 F.2d at 967. However, closer examination reveals that the source of the quotation is from an early version of the ERISA law that would have afforded pension claimants the opportunity to administratively pursue a grievance or arbitration proceeding before the Secretary of Labor. That portion of the bill was ultimately dropped in conference, though. *See,* 3 Legislative History of ERISA, 4769 at n.4. Thus, that rationale cannot provide the justification to import administrative law as the framework for adjudicating civil actions brought pursuant to ERISA.

Another rationale asserting the internal claim procedure mandated by 29 U.S.C. § 1133 is akin to

an administrative hearing is also misplaced. According to the House Conference Report, § 1133 was included as a compromise between the original House Bill, which had no such provision and the Senate Bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Ad.News 5038, 5108. Further, the absence of an evidentiary hearing or discovery proceedings during the "full and fair" internal claim review conducted pursuant to the claim regulations applicable to 29 U.S.C. § 1133, 29 C.F.R. §2560.503-1, underscores the need for plenary proceedings for plan participants who initiate civil actions to redress benefit claim denials.

This is further demonstrated by comparing the benefit claim regulations with other ERISA regulations that create an administrative procedure for adjudicating prohibited transaction penalties, with discovery and an explicit statement that ensuing civil actions are review proceedings. *Compare* 29 C.F.R. §§ 2560.502i-1, 2570.7, and 2570.11. In the absence of any comparable process for benefit claims contained in 29 C.F.R. § 2560.503-1, though, there is no basis for adjudicating ERISA benefit suits as review proceedings; and the plenary procedures afforded by the Federal Rules of Civil Procedure must be accorded plan participants seeking relief under 29 U.S.C. §1132(a)(1)(B).

Indeed, the Court has implicitly, if not explicitly, found the need for plenary proceedings to prevent ERISA civil actions from devolving into little more than reviews of claim records consisting

primarily of unsworn hearsay evidence. Thus, in *Massachusetts Mutual Life Insur.Co. v. Russell,* 473 U.S. 134, 144 (1985), the Court explained that the statutory provision authorizing a civil action under the ERISA law, 29 U.S.C. § 1132(a)(1)(B), "enables a claimant to bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits." More recently, in *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 385 (2002), the Court found:

> [ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations.* (citation omitted)(emphasis added).

Further, *Firestone* both addressed and rejected concerns that a plenary proceeding would "contravene the spirit of ERISA because it would impose much higher administrative and litigation costs and therefore discourage employers from creating benefit plans." 489 U.S. at 114. The Court determined "the threat of increased litigation is not

sufficient to outweigh the reasons for a *de novo* standard that we have already explained." 489 U.S. at 115.

Nor is it even appropriate to utilize an administrative law framework in ERISA litigation for the reasons set forth both by the Third and Seventh Circuits and as discussed in *Ramsey v. Hercules,* 77 F.3d 199, 205 (7th Cir. 1996), where the court remarked:

> Crucial differences exist between findings of fact made by a private entity such as a plan administrator, and findings made by duly authorized administrative law judges, agencies, or federal district courts. Underlying the deferential review that fact findings of the latter bodies enjoy is a well established set of procedural protections that stem from the Constitution and individual statutes. Plan administrators, in contrast, neither enjoy the acknowledged expertise that justifies deferential review for agency cases, see *Luby [v. Teamsters Health, Welfare, and Pension Trust Funds,* 944 F.2d 1176 (3d Cir. 1991)*]*, 944 F.2d at 1183, nor are they unbiased fact finders like the courts.

Following that ruling, in *Herzberger v. Standard Insur. Co.,* 205 F.3d 327 (7th Cir. 2001), the Seventh Circuit reiterated the point expressed

earlier in *Van Boxel v. Journal Co. Employees Pension Trust,* 836 F.2d 1048, 1050 (7th Cir. 1987) that "Pension fund trusts are not administrative agencies," nor are they "policy-makers; they are interpreters of contractual entitlements." *Herzberger* added that the courts have drawn an improper analogy between ERISA-governed disability benefit claims and Social Security claims, since the "Social Security Administration is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge." 205 F.3d at 332. No comparable protections exist when claims are adjudicated by private insurers. *Also see,* Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA," 101 Northwestern U.L.Rev. 1315, 1331-1333 (2007)(pointing out the inaptness of the use of administrative law guidelines in adjudicating ERISA cases).

Yet another consideration is that if the district court is merely reviewing a claim record assembled by an insurance company without conducting an evidentiary hearing, there is no means for the court to properly assess whether the claim determination is based on substantial evidence as the Court has defined that term in *Richardson v. Perales,* 402 U.S. 389, 402-406 (1971). *Perales,* which involved Social Security disability benefits, ruled that an examining physician's report may constitute substantial evidence in an administrative proceeding only when nine separately enumerated assurances of trustworthiness are met which include a

requirement that the report under consideration be prepared by a physician who has personally conducted a clinical, scientifically valid medical examination, and the claimant is allowed the opportunity to cross-examine the author of the report. ERISA claims, such as the instant case, frequently involve opinions generated by non-examining doctors who are not subject to cross-examination either during the pre-suit internal dispute resolution proceeding or in the ensuing civil action.

An additional difference that allows for receipt of medical reports in evidence in Social Security disability benefit disputes is that "the agency operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary." *Perales,* 402 U.S. at 403. In contrast, as the Eleventh Circuit has recognized, "Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross and Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1561 (11th Cir. 1990). Petitioner is aware that the Court will soon address that particular issue in *MetLife v. Glenn,* No. 06-923 (*certiorari granted* Janury 18, 2008); however, this case presents an entirely distinct issue that is only tangentially related.

Finally, as *Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402 (1971) points out, even in the administrative law context, the absence of procedural protections requires the district court to

conduct a plenary proceeding. In that proceeding, the court "may require the administrative officials who participated in the decision to give testimony explaining their action." 402 U.S. at 420. Hence, even if administrative law principles are properly utilized in adjudicating ERISA disputes, foreclosing evidentiary hearings as a rule is improper.

CONCLUSION

The issues raised in this petition merit review. The societal importance of employee benefits, coupled with the need for plenary consideration of civil actions authorized by Congress, mandates review by this Court. The Tenth Circuit's ruling is an aberration, inconsistent with the ERISA statute, its legislative history, and in conflict with rulings issued both by this Court and by the other Circuits.

For all of these reasons, Petitioner, Lynn Jewell, prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit.

Respectfully submitted,

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APPENDIX

LYNN JEWELL, Plaintiff-Appellee-Cross-Appellant, v. LIFE INSURANCE COMPANY OF NORTH AMERICA, Defendant-Appellant-Cross-Appellee.

Nos. 06-1272, 06-1288

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

508 F.3d 1303; 2007 U.S. App. LEXIS 27832

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Mark H. Kane, Kane Law Firm, P.C., Colorado Springs, Colorado, for Plaintiff-Appellee - Cross-Appellant Lynn Jewell.

JUDGES: Before McCONNELL, EBEL, and GORSUCH, Circuit Judges.

OPINION BY: McCONNELL

OPINION

McCONNELL, Circuit Judge.

The Life Insurance Company of North America ("LINA") appeals an order granting Lynn Jewell's claim for long-term disability benefits under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, ("ERISA"), arguing that the district court should not have considered three exhibits from outside the administrative record. Mr. Jewell cross-appeals, seeking an award of attorney's fees and an earlier date for the accrual of prejudgment interest. Because we hold that the district court abused its discretion in admitting and considering the extra-record exhibits, we reverse its judgment in LINA's appeal. Mr. Jewell's cross-appeal issues are therefore moot, and his appeal is dismissed.

I. FACTUAL AND PROCEDURAL HISTORY

A. Proceedings Before the Plan Administrator

Lynn Jewell was hired by Sprint Telecommunications Venture as a Director of National Sales and began work on April 21, 1997. Sprint's employee health benefits plan, in which Mr. Jewell participated, is underwritten and administered by LINA. Precisely a year later, on April 22, 1998, Mr. Jewell filed a claim for disability benefits, stating that he was "[u]nable to perform [his] job due to severe head pain, dizziness, misspelling, panic attacks where unable to do

anything, unable to lead people. Depressed. On medications." App. 566. LINA determined that he was disabled, paid him short-term benefits of $ 7003 per month from April 1998 until they ended in October 1998, and then agreed to pay him long-term benefits. Under the terms of the plan, if Mr. Jewell's disability was the result of physical injury or illness, his long-term benefits would last until age 65. If, however, the disability was "caused or contributed to by" depression or mental illness, they would expire after two years. App. 129.

In July 1999, LINA informed Mr. Jewell that it was paying under the mental illness limitation and that his benefit payments would end on October 18, 2000. LINA terminated Mr. Jewell's benefits on that date, and Mr. Jewell did not challenge the decision to do so. Nearly two years later, around the time his wife abandoned him and left him penniless, Mr. Jewell requested reconsideration of his benefit termination and reinstatement of the benefit payments, writing that "[t]hose benefits ended due to a mis-diagnosis, from day one. I should have been diagnosed with physical, organic and traumatic brain injuries, and I had a stroke. This is the actual cause of the cognitive difficulties and symptoms, which have caused me to be disabled." App. 373. He submitted additional medical information, but LINA denied his appeal on January 31, 2003. Mr. Jewell submitted a second appeal on September 15, 2003, along with a list of head injuries he claims he had suffered in the past. LINA denied that appeal on November 7, 2003.

B. Proceedings in Federal Court

Mr. Jewell then brought suit against LINA in state court in El Paso County, Colorado, for breach of contract and bad faith. On January 23, 2004, LINA removed the action to federal court, where it was converted to an ERISA claim arising under 29 U.S.C. § 1132(a)(1)(B). LINA moved for "judgment on the administrative record" on June 7, 2004. [1] Seeking to supplement the record beyond what LINA had compiled during the claim administration process, Mr. Jewell then moved for permission "to augment the record at the time of hearing with expert testimony." App. 658. The district court reserved ruling until specific evidence was presented, and on February 14, 2005, Mr. Jewell submitted three exhibits he sought to have included in the record.

1 The Federal Rules of Civil Procedure contemplate no such mechanism as "judgment on the administrative record." *Cf.* R. Ct. Fed. Cl. 52.1(b). Parties should avoid the practice of requesting it, and courts should avoid purporting to grant it. Doing so often creates unnecessary work for an appellate court in deciding whether to construe such a motion *ex post* as one for a bench trial "on the papers," *e.g., Hall v. UNUM Life Ins. Co of Am.,* 300 F.3d 1197, 1200 (10th Cir. 2002), or as one for summary judgment, *e.g., Gannon v. Aetna Life Ins. Co.,* F. Supp. 2d , No. 05 Civ. 2160, 2007 U.S. Dist. LEXIS 72529, 2007 WL 2844869, at *6 (S.D.N.Y Sept. 28, 2007). *See Muller v. First Unum Life Ins. Co.,* 341 F.3d 119, 124 (2d Cir. 2003).

The first exhibit was a February 7, 2005, letter from Bruce H. Peters, M.D., Mr. Jewell's neurologist, to Mark H. Kane, his attorney. The second was a February 9, 2005, letter from David U. Caster, M.D., Mr. Jewell's psychiatrist, to Mr. Kane. The third was an affidavit executed by Mr. Jewell on February 11, 2005. The district court accepted briefing from both parties on the admission of this extra-record evidence, and issued a written opinion on December 14, 2005. In its opinion, the court began by stating the applicable test for admission of extra-record evidence in *de novo* ERISA benefit denial reviews as put forth in our decision in *Hall v. UNUM Life Insurance Co. of America,* 300 F.3d 1197 (10th Cir. 2002). It found that the doctors' letters and Mr. Jewell's affidavit "do appear to include some information not contained in the administrative record that could assist the Court in understanding the medical issues in this case." App. 786. The district court then decided to admit the disputed exhibits.

On March 9, 2006, the district court held a hearing on the case, and granted judgment for Mr. Jewell. The court's oral opinion relied heavily on the letters of Drs. Peters and Caster. LINA then took this appeal, arguing that the extra-record exhibits should not have been admitted under the *Hall* standard and that the district court's consideration of them tainted its judgment, requiring reversal. We begin with a discussion of *Hall* and the rules it provides for admission of extra-record evidence and then consider, first, whether the doctors' letters should have been admitted; second, whether Mr. Jewell's affidavit should have been admitted.

II. DISCUSSION

A. Standard for Admission of Extra-Record Evidence

ERISA, a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361, 100 S. Ct. 1723, 64 L. Ed. 2d 354 (1980), governs employee benefit plans, including disability benefit plans such as LINA's. When an individual covered by the plan makes a claim for benefits, the administrator gathers evidence, including the evidentiary submissions of the claimant, and determines under the plan's terms whether or not to grant benefits. If the administrator denies the claim, the claimant may bring suit "to recover [the] benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Federal court is the exclusive forum for such suits, as ERISA preempts state laws relating to nearly all private employee benefit plans. *Id.* § 1144(a).

Where, as here, a plan administrator did not have "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," district courts will review a benefit denial *de novo*. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). Although ERISA provides federal review for benefit denials, this does not entail that federal courts should "function as substitute plan administrators." *Hall*, 300 F.3d at 1201 (quoting *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990)). Consequently we have said that "the best way" for a district court "to implement ERISA's purposes in this context is ordinarily to restrict de novo review to

the administrative record" compiled during the claim administration process, instead of taking new evidence, hearing witnesses, and the like. *Id.* at 1202.

Confining review in general to the administrative record, and thus encouraging the parties to develop the factual record as fully and as early as possible, is important for a variety of reasons related to the goals of ERISA. For instance, it may avert problems related to the loss or staleness of evidence, since federal suits may be brought years after a disputed decision. More importantly, the availability of a complete factual record makes it easier for the plan administrator to come to an objectively correct, well-supported determination; this, in turn, decreases both the likelihood of subsequent federal litigation and the costs that would be attendant thereto. "ERISA was designed to promote internal resolution of claims, . . . and to encourage informal and non-adversarial proceedings," and these related aims are promoted by early and full development of the factual record before the administrator, rather than the federal district court. *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1022 (4th Cir. 1993) (quoting *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1007 n.4 (4th Cir. 1985) (internal quotation marks and further citation omitted)). As we indicated in *Hall*, a fully developed administrative record facilitates "the goal of prompt resolution of claims by the fiduciary under the ERISA scheme." 300 F.3d at 1201. And if litigation should ensue, requiring the parties to have developed the record during the claim administration process deters the practice of

holding back evidence for presentation to the district court as a fallback or a "surprise."

In *Hall,* this Court first had occasion to consider the standard for admission of evidence from outside the administrative record in the *de novo* review of an ERISA plan administrator's benefit determination. We made clear that "it is the unusual case in which the district court should allow supplementation of the record," 300 F.3d at 1203, and that only "exceptional circumstances could warrant the admission of additional evidence." *Id.* Today we again emphasize that ERISA policy strongly disfavors expanding the record beyond that which was available to the plan administrator. Supplemental evidence should not be used to take a second bite at the apple, but only when necessary to enable the court to understand and evaluate the decision under review.

A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, (1) the evidence must be "necessary to the district court's de novo review"; (2) the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made"; (3) the evidence must not be "[c]umulative or repetitive"; nor (4) may it be "evidence that 'is simply better evidence than the claimant mustered for the claim review.'" *Hall,* 300 F.3d at 1203 (quoting *Quesinberry,* 987 F.2d at 1027). [2] Even then, "district courts are not required to admit additional evidence when these circumstances exist because a court 'may well

conclude that the case can be properly resolved on the administrative record without the need to put the parties to additional delay and expense.'" *Id.*

> 2 Most often it is the claimant who seeks to introduce new evidence in the review of a benefit denial. But the same standard will apply to new evidence offered to the district court by a plan administrator. *See Hall,* 300 F.3d at 1202.

For guidance in evaluating the necessity of extra-record evidence, we listed in *Hall* several examples of the "exceptional circumstances" which "could warrant the admission of additional evidence." *Id.* Those situations include

> claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.

Id. (quoting *Quesinberry,* 987 F.2d at 1027). These are not exceptions to the *Hall* rule; they are merely examples of circumstances that might militate in favor of a finding of necessity. The existence of one or more of these circumstances does not make extra-record evidence automatically admissible, for if it did, then supplementation of the record would not be limited to unusual cases or extraordinary circumstances. This would "undermin[e] the goal of not making district courts 'substitute plan administrators.'" *Id.* at 1206 (quoting *Quesinberry,* 987 F.2d at 1025). District courts must conduct analysis case-by-case to determine whether all four prongs of the *Hall* test are met.

This Court reviews the district court's ultimate determination under *Hall* for an abuse of discretion.

B. Letters of Dr. Peters and Dr. Caster

The district court's entire explanation of its decision to admit the 2005 letters of Drs. Peters and Caster was the brief statement that they "do appear to include some information not contained in the administrative record that could assist the Court in understanding the medical issues in this case." App. 786. That thin basis, however, is insufficient for admitting evidence under *Hall,* and a full analysis according to our precedent does not support admission of the letters either.

"In making a discretionary decision, a court must present an explanation for its choice sufficient to enable a reviewing court to determine that it did not act thoughtlessly, but instead considered the factors

relevant to its decision and in fact exercised its discretion." *Patton v. MFS/Sun Life Fin. Distribs., Inc.*, 480 F.3d 478, 491 (7th Cir. 2007); *see also, e.g., O'Toole v. Northrop Grumman Corp.*, 499 F.3d 1218, 1226 (10th Cir. 2007) (district court must explain its discretionary denial of prejudgment interest); *Okland Oil Co. v. Conoco Inc.*, 144 F.3d 1308, 1329 (10th Cir. 1998) (district court must provide "adequate explanation" of its discretionary denial of costs). Here, the district court accurately recited the terms of the *Hall* test, but its conclusory analysis failed to explain how the doctors' letters might meet these requirements for admissibility.

To be sure, the district court stated that the letters "could assist the Court" in its review. App. 786. But evidence that is potentially helpful is not perforce "*necessary* to the district court's de novo review," *Hall* 300 F.3d at 1203 (emphasis added). We discuss the nuances of the term "necessary" below, *see infra* § II.B.1, but suffice it here to say that the word connotes a stronger requirement than the mere possibility of utility. And although the district court's opinion shows that the letters were not merely "cumulative or repetitive" of the other evidence already in the record, *Hall*, 300 F.3d at 1203, it does nothing to indicate that the other factors of the *Hall* test were met. Specifically, the court did not explain why this evidence "could not have been submitted to the plan administrator at the time the challenged decision was made," or why it was not "'simply better evidence than the claimant mustered for the claim review.'" *Id.* (quoting *Quesinberry*, 987 F.2d at 1027). Without more than its meager finding that the

letters might perhaps be useful, the district court should not have admitted them.

If our own analysis of the letters showed that they were admissible on a basis the district court did not provide, "we may nonetheless affirm . . . 'in the interest of efficiency and judicial economy.'" *Id.* at 1207 (quoting *Ohlander v. Larson,* 114 F.3d 1531, 1538 (10th Cir. 1997)); *see also Hill v. SmithKline Beecham Corp.,* 393 F.3d 1111, 1116 (10th Cir. 2004). Applying the *Hall* test ourselves further persuades us that the letters' admission was an abuse of discretion.

1. Necessity of Extra-Record Evidence

First, extra-record evidence must be "necessary to the district court's de novo review." *Hall,* 300 F.3d at 1203. "Necessary" is a term with a spectrum of meanings. At one end, it may "import an absolute physical necessity, so strong, that one thing, to which another may be termed necessary, cannot exist without that other"; at the opposite, it may simply mean "no more than that one thing is convenient, or useful, or essential to another." *McCulloch v. Maryland,* 17 U.S. 316, 4 L. Ed. 579, 4 Wheat. (17 U.S.) 316, 413 (1819); *cf. Colautti v. Franklin,* 439 U.S. 379, 400, 99 S. Ct. 675, 58 L. Ed. 2d 596 (1979) ("necessary" in abortion statute suggested "indispensable"); *Comm'r v. Tellier,* 383 U.S. 687, 689, 86 S. Ct. 1118, 16 L. Ed. 2d 185 (1966) ("necessary" in tax statute meant "appropriate and helpful"). Neither end of this spectrum, we think, is appropriate here.

Too strict a view of necessity is foreclosed by our very holding in *Hall.* There, we allowed admission of

evidence regarding two surgeries which took place after the closing of the administrative record. The decisive issue in *Hall* was the degree of the plaintiff's enduring pain, and we agreed with the district court that the fact the plaintiff chose to undergo the surgeries was strong evidence that her pain was "real and unrelenting." 300 F.3d at 1206 (internal quotation marks omitted). The evidence was not, however, absolutely indispensable to reviewing the plan administrator's decision. On the other hand, "necessary" evidence in this context cannot be evidence that is merely "convenient, or useful," or "conducive to the end" of conducting review. *Cf. McCulloch,* 4 Wheat. at 413, 415. If this were what the term meant, the admission of extra-record evidence would not be limited to unusual cases or extraordinary circumstances, as we require. *See Hall,* 300 F.3d at 1206 (quoting *Quesinberry,* 987 F.2d at 1025). [3]

3 In *Ray v. Unum Life Insurance Co. of America,* 314 F.3d 482 (10th Cir. 2002), we reversed a district court's abuse-of-discretion review of an ERISA benefit denial and ordered the court to perform *de novo* review as required under *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). Under abuse-of-discretion review, a district court is unable to supplement the administrative record. *See Hall,* 300 F.3d at 1201. We accordingly observed that "[o]ur remand allows the district court to consider such additional evidence as in its discretion it finds *necessary* for adequate de novo review, including court-appointed expert reports if it

> determines them *helpful*." *Ray,* 314 F.3d at 488 (emphasis added). Because no issue of supplementation of the record was before the *Ray* court, this statement was dictum. In any event, we have never determined, and do not now decide, whether the *Hall* test properly applies to extra-record evidence from *court-appointed* experts. The incentives, and the policy considerations favoring early and full development of the administrative record, are not the same for the district judge as for the ERISA litigant. (We subsequently affirmed the district court's decision, upon remand, not to appoint an expert and to render judgment on the administrative record alone. *Ray v. UNUM Life Ins. Co. of Am.,* 224 F. App'x 772, 780 (10th Cir. 2007).)

Rather, the term "necessary," as we used it in *Hall,* must be "harmonized with its context." *Armour & Co. v. Wantock,* 323 U.S. 126, 130, 65 S. Ct. 165, 89 L. Ed. 118 (1944). We are guided by our qualification in *Hall,* following the Fourth Circuit's opinion in *Quesinberry,* that extra-record evidence may be admitted when "'necessary to conduct an *adequate* de novo review of the benefit decision.'" *Hall,* 300 F.3d at 1202 (emphasis added) (quoting *Quesinberry,* 987 F.2d at 1025). If, for instance, the administrator based its decision on information not in the record--perhaps on principles generally known within the medical community--the district court likely could not meaningfully review the decision without the admission of that evidence. Or if the court cannot understand abstruse medical terminology central to the issues of a case, the

claimant may supplement the record with explanatory evidence. Likewise, if the administrator simply neglected to include in the record exhibits the claimant had submitted to it, those may be offered to the district court. (Even "necessary" evidence, however, may only be admitted if the other three prongs of the *Hall* test are satisfied. The consequences of a record insufficient to allow meaningful review will be borne by the party responsible for the insufficiency.)

Mr. Jewell suggests that admission of the letters of Dr. Peters and Dr. Caster was justified by one or more of the "exceptional circumstances" which we said in *Hall* "could warrant the admission of additional evidence." 300 F.3d at 1203. First, Mr. Jewell argues that the proper diagnosis of his disorder is a "complex medical question" and requires additional explanatory evidence. Appellee's Opening Br. 32. The letters, however, provide no assistance to a court seeking to resolve on *de novo* review the medical complexities of the case. They state a diagnosis, but there are other diagnoses already in the record--from Dr. Peters and Dr. Caster as well as from four other doctors. The letters do not elucidate the medical principles or terminology, nor offer any account of how the facts support the diagnosis. The letters are, in a sense, black boxes: facts go in, diagnoses come out. When doctors offer new or revised diagnoses several years after the fact, one would expect to see explanations of what has changed and why. A doctor's mere announcement of a new conclusion is not evidence genuinely directed toward helping a court engage in *de novo* review of the decision previously made.

Second, Mr. Jewell argues that, by disbelieving what he claims was his doctors' diagnosis of an organic disorder, LINA put the doctors' credibility at issue. The question of the credibility of an expert--as opposed to the question of the reliability of the expert's conclusions--concerns whether the expert is believable. *See, e.g., Washington v. Schriver,* 255 F.3d 45, 52 (2d Cir. 2001). Credibility embraces such matters as professional qualifications, mental capacity, bias and interest, and bad moral character. So, for instance, the size of an expert's fee or the fact that he only testifies for plaintiffs in civil cases may be relevant to his credibility. *See* Edward J. Imwinkelried, *The Silence Speaks Volumes,* 1998 U. Ill. L. Rev. 1013, 1034-35. Whether, as is important here, these doctors were correct, or whether their conclusions were based on sufficient evidence and sound medical science, bears on their credibility in no genuine sense. And although LINA's brief before this Court contains a few vague references to the doctors' credibility--calling them "loyal" to Mr. Jewell and stating that "for reasons we do not know, a few doctors agreed to modify their diagnoses," Appellant's Opening Br. 39, 63--those comments were in reaction to the recent letters; the letters were not responsive to any pre-existing challenges to the doctors' credibility. Even if they were, the statements and diagnoses contained in these letters have nothing to do with the doctors' qualifications, bias or interest, or the like. We cannot conclude that consideration of these letters would be at all helpful to evaluating the doctors' credibility, properly understood; still less that the district court could not conduct meaningful review without them.

Mr. Jewell further argues that the letters are necessary to prove that his disability is ongoing. Dr. Caster's letter, in particular, indicates that, although Mr. Jewell's financial situation had improved by the time of writing, nevertheless "this man can not be gainfully employed," and "his [sic] is unable to adequately function, not only because of poor cognitive processing and poor attention and difficulties around cognition, but also because of a worsening at these times of his depression." App. 744. LINA, however, does not contest that Mr. Jewell is disabled, or indeed that he has been since it began paying him benefits in 1998. The issue in this case is the cause of his disability, not its duration. Nor has Mr. Jewell presented any evidence or argument tending to show that the ongoing character of his disability would be proof of an organic cause. Because the necessity of extra-record evidence must be established by its proponent, *see Hall,* 300 F.3d at 1203, Mr. Jewell has not met his burden with respect to this argument.

2. Inability to Present Evidence During Administrative Process

Second, the party attempting to bring evidence before the district court which it did not offer to the plan administrator must "demonstrate that [the evidence] could not have been submitted . . . at the time the challenged decision was made." *Hall,* 300 F.3d at 1203. [4] During the claims administration process a claimant must come forward with all evidence which he knows or should know. *See Davidson v. Prudential Ins. Co. of Am.,* 953 F.2d 1093, 1095 (8th Cir. 1992). By "evidence," we of course mean not just the particular document or

testimony that a claimant might offer to the district court, but its substance.

> 4 Alternatively, an ERISA claimant may demonstrate that he did submit the evidence to the administrator, and that due to the administrator's default it was not included in the record.

In this case, then, it is not enough for Mr. Jewell to demonstrate that he could not have offered to LINA the particular letters in question. The letters were written some thirteen months after this litigation was commenced in state court, so meeting that requirement would be trivial. Rather, he must show that the information contained in those letters was not of a substance known to him, or which should have been known to him, during the administrative process. We agree with the Eighth Circuit that where "additional evidence," now believed by the claimant to be necessary to the benefit determination, is "created *after* litigation had begun, [but] was known or should have been known to [the claimant] *during* the administrative proceedings," the claimant's subsequent proffer of that evidence "amounts to nothing more than a last-gasp attempt to quarrel with" the administrator's benefit determination, and should not be permitted. *Id.* (emphasis added).

In the first disputed letter, dated February 7, 2005, Dr. Peters states that he had conducted three examinations of Mr. Jewell: on December 9, 1999, November 11, 2002, and January 13, 2003. (Dr. Peters' notes from those examinations were already in the administrative record compiled by LINA.) Mr.

Jewell has offered no reason why he could not have solicited this explanatory letter promptly, instead of waiting two years after the last examination to do so. Nor do the contents of the letter seem to be outside the scope of information that was known or should have been known to Mr. Jewell during the administrative process. The only new matter of real substance in the letter is the claim that Mr. Jewell could be diagnosed with complex partial seizure disorder, apparently an organic defect, on the basis of his clinical history alone, and that "any type of seizure is never diagnosed on the basis of [an] electroencephalogram." App. 734. But in the same letter Dr. Peters states that this clinical-history method of diagnosing seizures is "well-known and even axiomatic in the neurologic community." App. 734. If so, it is information Mr. Jewell should have known, and could have presented to the plan administrator, long before 2005. Dr. Peters' letter, therefore, fails under this prong of the *Hall* admissibility test. *See also Davidson,* 953 F.2d at 1095.

The second disputed letter, that of Dr. Caster dated February 9, 2005, begins by reprinting verbatim the six paragraphs of a 2002 letter from Dr. Caster which was already in the administrative record. The next paragraph contains information relating to the period up to June 2003, which could have been presented to LINA during Mr. Jewell's administrative appeals. The final paragraph, however, contains a statement that Mr. Jewell had suffered grand mal seizures in March 2003 and July 2004, names the medicines Mr. Jewell was subsequently prescribed "specifically to treat seizure

activity and other manifestations of his organic mental disorder," and opines that Mr. Jewell's condition continued to be completely disabling up to the time the letter was written. App. 743. The first seizure was reported by Dr. Caster elsewhere in the record in an April 18, 2003 note. The rest, however, was new information concerning events that had not occurred by the time the administrative record was closed; the second seizure and subsequent treatment history could not have been presented to LINA during the claim administration. These portions of Dr. Caster's letter accordingly would survive the second prong of the *Hall* test.

3. Cumulative and Repetitive Evidence

In an ordinary trial, evidence, even though relevant, may be excluded if "its probative value is substantially outweighed . . . by considerations of . . . needless presentation of cumulative evidence." Fed. R. Evid. 403. The trial judge's discretion is wide, because cumulative evidence is excluded in the interests of trial efficiency, time management, and jury comprehension. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 230, 60 S. Ct. 811, 84 L. Ed. 1129 (1940). Under *Hall*, however, a judge *must* refuse admission to any extra-record evidence that is "[c]umulative or repetitive." 300 F.3d at 1203. In this context, the concern is not only that cumulative evidence is a waste of time, but also, as discussed above, that all relevant evidence should be developed and presented to the plan administrator as early as possible. Parties may not easily be able to judge at the administrative stage whether evidence will be important or merely cumulative. Accordingly, under *Hall*, the exclusion of new, cumulative

evidence is not merely discretionary, so as to avoid waste of time; it is mandatory, to spur the presentation of *all* potentially relevant evidence to the administrator.

Evidence is cumulative if its probative effect is already achieved by other evidence in the record; that is, "if the small increment of probability it adds may not warrant the time spent in introducing it." *United States v. Davis*, 40 F.3d 1069, 1076 (10th Cir. 1994) (internal quotation marks and citation omitted). It is distinguished from corroborating evidence, which buttresses weak or assailable evidence, often by "establishing data which refute possible discrediting circumstances." 2 John Henry Wigmore, A Treatise on the Anglo-American System of Evidence in Trials at Common Law § 874, at 235 (1923). New evidence need not be identical to previous evidence to be cumulative, but only of the same general substance, related to the same fact or point, and of little additional probative value.

Although large portions of the letters of Dr. Peters and Dr. Caster were cumulative, we cannot conclude that the letters were cumulative *in toto*. Mr. Jewell's claim of an organic seizure disorder was not "established" by the evidence in the administrative record to the point of needing no further support--indeed, LINA advances that, without the disputed letters, the court should find that Mr. Jewell failed to prove the existence of an organic disorder at all. The additional grand mal seizure Dr. Caster mentions, as well as the seizure medication, is corroborative evidence.

Likewise, we cannot say that the "well-known and even axiomatic" proposition Dr. Peters invokes--that no type of seizure is ever diagnosed on the basis of an electroencephalogram--was already established in the administrative record. True, the record contained Dr. Peters' 2002 clinical note commenting that "it is not demanded that a diagnosis of seizure disorder be documented by an electroencephalogram but it is a helpful certifying finding." App. 293. But Dr. Peters' clinical notes also reveal that in 1999 he ordered an EEG to "make a decision" about whether "this man has complex partial seizures," App. 325, and that in 2002 he did so once more, noting that "the electroencephalogram is again of great importance in assisting with differentiation of a primarily functional from a primarily organic circumstance." App. 294. (These EEGs showed no significant abnormalities.) There is obvious tension between Dr. Peters' various statements, and the 2005 letter can be read as resolving this tension by repudiating some of the earlier statements--rejecting the "great importance" of the EEG and the notion that one could "make a decision" about complex partial seizure disorder on the basis of an EEG, after the EEGs turned out not to "certify[]" the doctor's suspicions. The letter reinforces the earlier claim that although an abnormal EEG might be "helpful" it is "not demanded" for a diagnosis. In this sense, whatever other questions this letter may raise, we cannot say that it was cumulative of other facts "established" in the administrative record.

4. "Simply Better Evidence"

Finally, *Hall* requires that extra-record evidence presented to a district court not be "'simply better

evidence than the claimant mustered for the claim review.'" 300 F.3d at 1203 (quoting *Quesinberry,* 987 F.2d at 1027). We have not yet explained what this requirement entails. We think it is clear from the context of *Hall* that new evidence which is *of the same kind* as evidence in the administrative record, but simply more persuasive, is not admissible. New evidence must be of a significantly different type than existing evidence to meet the standard of *Hall.*

In *Hall,* we permitted the introduction of extra-record evidence of the plaintiff's two subsequent surgeries because "the probative value of the surgeries was far greater than the probative value of the evidence of Hall's pain in the administrative record," and so the surgeries were of "obvious importance . . . to the question of whether she was disabled." 300 F.3d at 1207. The issue of Ms. Hall's disability turned on the extent of her pain, a subjective matter which is not susceptible of objective measurement, and the only information in the administrative record from which answers could be gleaned were the statements of Ms. Hall and her doctors, plus the fact of Ms. Hall's heavy use of pain medication. *See Hall v. Unum Life Ins. Co. of Am.,* No. 97-CV-1828, 1999 WL 33485551, at *2-*7 (D. Colo. Nov. 1, 1999). And on this subjective question, Ms. Hall's credibility was at issue, as her "demeanor and manner while giving her testimony suggest[ed] that she was exaggerating her difficulty." *Id.* at *8. Against this background, then, her choice to undergo pain-relieving surgeries that removed muscle tissue and her first rib, *id.* at *7, constituted verifiable and hard-to-manipulate corroborating evidence of a kind to be found nowhere else in the record. As the

district court noted, "[i]t is highly unlikely that any person would undergo those procedures unless the pain she experienced was real and unrelenting." *Id.* The surgeries were more than merely better or more convincing versions of Ms. Hall's testimony and the conclusions of her doctors.

The letters at issue in this case do not meet this standard. Above, we observed that Dr. Peters' assertion of the insignificance of the EEG in diagnosing complex partial seizure disorder appears to repudiate some of his earlier statements and actions. It might, if true, be stronger or clearer evidence than Mr. Jewell had previously mustered of what method should be used to diagnose his problems. It is certainly more emphatic. To this extent, however, it is "simply better evidence"--evidence perhaps more favorable or more persuasive but certainly not different in kind--than what was in the administrative record. The record already contained Dr. Peters' contemporaneous views, and extra-record evidence cannot be used to edit or redo the record. *Hall* forbids precisely this sort of second bite at the apple. Similarly, although Dr. Peters' letter states more emphatically than did his previous notes that he believes Mr. Jewell's disorder to be organic in nature, this again cannot not meet the *Hall* standard.

As to Dr. Caster's letter, the reference to a 2004 seizure and to Mr. Jewell's seizure medication are not enough to make the letter admissible. There was already evidence in the record of the possibility that Mr. Jewell had had seizures. Dr. Peters reported as early as November 9, 1999 that Mr. Jewell "has no history of generalized seizures," but that "I am quite

concerned that this man has complex partial seizures." App. 323, 325. His physician Dr. Lisa Dunham had recorded on November 6 and November 14, 2002, that Mr. Jewell "reports recently having seizure type activity" and that he had had "episodes suspicious for seizure disorder." App. 180, 182. Dr. Peters wrote on November 11, 2002, that Mr. Jewell "reports having episodes where he has found himself where he hadn't known he had been (once in the basement) and thinks that he must have had a seizure." App. 293. Another doctor, Patricia Fodor, wrote in a December 3, 2002 clinic note that Mr. Jewell had a "history of seizures." App. 321. Dr. Caster recorded on April 18, 2003 that "[i]t is apparent that [Mr. Jewell] had a seizure about a month ago." App. 254. There was in the record, as well, some contradictory evidence: most or all of these seizures appear to have occurred after a May 12, 2002 motorcycle accident which left Mr. Jewell unconscious, with, as Dr. Caster put it, "fairly significant physical injuries with evidences [sic] of a head injury." App. 252. Even assuming that the 2004 seizure and use of seizure medication reported in Dr. Caster's disputed letter is evidence that Mr. Jewell's disability, which manifested itself in 1998, was organic in nature, the letter would be "simply better evidence" of conditions already documented in the record. Finally, Dr. Caster's statements that Mr. Jewell's finances had improved but that his disability continued, to the extent they are relevant, cast no light on the medical provenance of his condition.

* * * *

In sum, the district court offered no indication that the extra-record letters of Dr. Peters and Dr. Caster met the requirements we identified in *Hall* for admissibility. Neither has Mr. Jewell on appeal met his burden of showing that those requirements were satisfied. We therefore hold that the admission and consideration of these letters was an abuse of the district court's circumscribed discretion under *Hall*.

C. Affidavit of Mr. Jewell

The district court admitted Mr. Jewell's affidavit saying only that, along with the Peters and Caster letters, it "could assist the Court in understanding the medical issues in this case." App. 786. We cannot agree. Mr. Jewell made out the affidavit, apparently, because "[i]t is my understanding that my credibility has come under attack in arguments present [sic] by the Defendant." App. 746. In the affidavit, Mr. Jewell briefly recounts the history of his employment at Sprint and his disability, and he states that although his condition has not "substantially changed" since October 2000 it "may have deteriorated." App. 748. He further denies that he "fooled" his doctors into changing their diagnosis or that the impecuniousness caused by his divorce was what motivated him to reopen his benefits claim after nearly two years. App. 747-48.

This affidavit does not meet the requirements imposed by *Hall*. The substance of the affidavit was entirely within Mr. Jewell's knowledge during the claim administration process, and the affidavit contains no information relating to events occurring after September 15, 2003, the date of Mr. Jewell's

final administrative appeal. [5] There is nothing in the affidavit that "could not have been submitted to the plan administrator at the time the challenged decision was made." *Hall,* 300 F.3d at 1203. Nor was the affidavit "necessary" to an adequate review by the district court. It has no particular relevance to "understanding the medical issues in this case," App. 786, so the district court's reason for accepting it fails. The only arguable relevance of the affidavit to any issue in the case might be as an attempt to bolster the credibility of the plaintiff's doctors. In that respect, the affidavit fails as well, both because the credibility of Mr. Jewell's doctors has never been seriously questioned and because the minimal additional assurance of their credibility that this affidavit would provide is not "necessary to the district court's de novo review." *Hall,* 300 F.3d at 1203. Under the strict standard of *Hall,* the district court's decision to admit Mr. Jewell's affidavit was an abuse of discretion.

> 5 Certain statements relating to later events, such as the passage quoted above, are merely prefatory and therefore immaterial to our analysis.

D. Harmless Error

Because we conclude that the admission of the three extra-record exhibits Mr. Jewell offered was erroneous, we must next consider whether that error was harmless. *See Hall,* 300 F.3d at 1207 n.4; *Tester v. Reliance Std. Life Ins. Co.,* 228 F.3d 372, 377 n.4 (4th Cir. 2000). The district court's brief oral opinion rendering judgment on the record against LINA

shows that the error was not harmless. A substantial part of the court's analysis was directed to the erroneously admitted letters; the district judge referred several times to the specific findings of Drs. Peters and Caster, each time citing only those letters. App. 833-34. The court continued:

> So we have these very strong letters by two doctors who appear to be strong in their opinions and who appear to really have a great understanding of this area. I'm not a specialist. Neither of the attorneys are specialists or even doctors. Or maybe you are, but I don't know that. And all we can do in a case like this is rely on the understanding of the doctors.
>
> And I think the two main doctors that we must rely on are Peters and Caster; the neurologist and psychiatrist . . . .

App. 835. The district court's analysis of the entire remaining corpus of the administrative record amounted to no more than passing mention.

Accordingly, it appears that the erroneously admitted letters had a substanial effect on the district court's disposition of the case and cannot be dismissed as harmless. We must therefore reverse the judgment below.

E. Remand

LINA suggests that this Court, having reversed, should dispense with remand and conduct our own

de novo review of the benefit determination--in other words, that we should play the role of the district court. If doing so is within the discretion of a court of appeals at all, we should exercise that discretion sparingly. We decline LINA's invitation to conduct review of the merits of the case on the basis of the appellate briefs and records, and so remand to the district court for *de novo* review based on the administrative record.

III. CONCLUSION

For these reasons, the judgment of the United States District Court for the District of Colorado is **REVERSED** in No. 06-1272, and the matter **REMANDED** to that court for further proceedings not inconsistent with this opinion. Mr. Jewell's cross-appeal, No. 06-1288, is **DISMISSED** as moot.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 04-cv-00122-ZLW-BNB

LYNN JEWELL,

Plaintiff,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Defendant.

JUDGMENT

Pursuant to the Court's Order dated March 9, 2006, the Court's Order dated May 10, 2006, and for good cause shown, the Court enters the following final judgment in this action:

1. Plaintiff is awarded past due long-term disability benefits in the amount of $345,475.11.

2. Plaintiff is awarded prejudgment interest in the amount of $210,221.54, which represents interest at the rate of 5% with an accrual date of September 30, 2002, calculated on a monthly basis under the formula set forth in *Reed v. Mineta*, 438 F.3d 1063 (10th Cir. 2006).

3. The total amount of past due long-term disability benefits prejudgment interest is $555,696.65.

4. Plaintiff will receive future long-term disability benefits subject to and in accordance with the terms and conditions of the long-term disability policy and the long-term disability plan.

5. The parties shall pay their own costs and attorney fees.

DATED at Denver, Colorado, this 1 day of June, 2006.

BY THE COURT:

/s/ Zita L. Weinshienk

ZITA L. WEINSHIENK, Senior Judge
United States District Court

Supreme Court, U.S.
FILED
071121 FEB 19 2008
OFFICE OF THE CLERK

No.

In The
Supreme Court of the United States

LYNN JEWELL,

Petitioner

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Respondent

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

SUPPLEMENTAL APPENDIX

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In the United States District Court
For the District of Colorado
Senior Judge Zita L. Weinshienk
March 9, 2006

Darlene Martinez, Court Reporter
LaDonne Bush, Deputy Clerk

Civil Action No. 04-cv-00122-ZLW-BNB

LYNN JEWELL,

Plaintiff,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Defendant.

COURTROOM MINUTES

Hearing on LINA's Motion for Judgment On The Administrative Record

2:00 p.m. Court in Session.

Appearance of counsel.

2:04 p.m. Argument by Mr. Englert.

2:30 p.m. Argument by Mr. Kane.

2:47 p.m. Rebuttal argument by Mr. Englert.

Court's conclusions of law.

ORDERED: LINA'S Motion for Judgment On The Administrative Record (Doc. No. 14), filed June 7, 2004, is denied.

ORDERED: Judgment will enter in favor of Plaintiff. Plaintiff shall be awarded his past due long-term disability benefits. Defendant is obligated to pay Plaintiff his ongoing long-term disability benefits under the long-term disability policy. The parties shall pay their own costs and attorney fees.

Discussion regarding the calculation of benefits.

ORDERED: No later than March 26, 2006, counsel shall submit a proposed judgment or joint status report.

Discussion regarding prejudgment interest.

3:07 p.m. Court in Recess.

Hearing concluded. Total time in court: 01:07.

In the United States District Court
For the District of Colorado
Senior Judge Zita L. Weinshienk

Civil Action No. 04-cv-0122-ZLW-BNB

LYNN JEWELL,

Plaintiff,

v.

LIFE INSURANCE COMPANY
OF NORTH AMERICA,

Defendant.

ORDER

On March 29, 2006, the Court ordered the parties to submit briefs addressing the issue of prejudgment interest. The Court has reviewed the parties' briefs (Doc. Nos. 112, 113, 114, 115) and the authority cited herein. An award of prejudgment interest in an ERISA case must be compensatory only and not punitive.[1] Given prevailing rates of return during the relevant period, the Court finds that a prejudgment interest rate of five percent adequately compensates Plaintiff for his loss of use of the benefits to which he was entitled.[2] Moreover, prejudgment interest in this case properly is

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[1] Allison v. Bank One – Denver, 289 F.3d 1223, 289 (10th Cir. 2002).

[2] *See* Ray v. Unum Life Ins. Co., 2005 WL 1994247 (D. Colo.).

calculated with an accrual date of September 30, 2002, the date that Defendant first was notified of Plaintiff's request for reconsideration, not October 2000, since Plaintiff did not challenge the termination of his benefits in October 2000.[3] The parties agree that the incremental calculation method set forth in Reed v. Mineta[4] applies here. Accordingly, it is

ORDERED that Plaintiff is awarded prejudgment interest at the rate of five percent. It is

FURTHER ORDERED that prejudgment interest shall be calculated with an accrual date of September 30, 2002. It is

FURTHER ORDERED that prejudgment interest shall be calculated on a monthly basis under the formula set forth in Reed v. Mineta.[5] It is

FURTHER ORDERED that Plaintiff shall file a proposed Judgment in conformity with this Order and the Court's Order of March 9, 2006, approved by both parties as to form, on or before May 30, 2006.

DATED, at Denver, Colorado, this 10 day of May, 2006.

BY THE COURT:

---

[3] *See* Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, 1287 (10th Cir. 2002).

[4] 438 F.3d 1063 (10th Cir. 2006).

[5] Id.

/s/ Zita L. Weinshienk
Zita L. Weinshienk, Senior Judge
United States District Court

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(3)

No. 07-1121

FILED
MAR 30 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE
Supreme Court of the United States

LYNN JEWELL,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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April 30, 2008

Counsel for Respondent

QUESTION PRESENTED

Whether this Court should review an issue that was not presented to or decided by the court of appeals, and as to which there is no circuit conflict justifying review, namely, whether an action challenging an ERISA plan administrator's termination of benefits under 29 U.S.C. § 1132(a)(1)(B) requires a "plenary proceeding."

RULE 29.6 STATEMENT

Respondent Life Insurance Company of North America is a wholly owned subsidiary of Connecticut General Corporation, which is a wholly owned subsidiary of CIGNA Holdings, Inc., which is a wholly owned subsidiary of CIGNA Corporation. CIGNA Corporation is the only publicly traded entity among this group of affiliated companies.

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INTRODUCTION

This is an unremarkable case under Section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), which authorizes a federal civil action "to recover benefits due . . . under the terms" of an ERISA-governed employee benefit plan. Petitioner Lynn Jewell challenged the termination of long-term disability benefits by Respondent Life Insurance Company of North America ("LINA"). Applying settled principles of law to the specific facts of this case, a unanimous panel of the Tenth Circuit concluded that the district court abused its discretion by allowing Jewell to supplement the evidentiary record considered by LINA with two physicians' letters and Jewell's own affidavit. The letters and affidavit were generated years after LINA's benefits determinations, and did not meet the Tenth Circuit's established standards for the introduction of extra-record evidence in Section 1132(a)(1)(B) cases. The Tenth Circuit remanded the case for further proceedings based on the trial court's consideration of the unsupplemented record.

Jewell asks this Court to rule that Section 1132(a)(1)(B) automatically entitles every ERISA claimant to a "plenary proceeding," rather than a review of the materials presented to and considered by the plan administrator, as supplemented by additional evidence where appropriate. Jewell never previously raised the question he asks this Court to decide, and as a result the Tenth Circuit did not address the issue. Also, there is no circuit conflict. In fact, the Seventh Circuit applies precisely the

same rule as the Tenth Circuit did in this case. Nor is any other Circuit in conflict on the question Jewell seeks to have considered. Thus, there is no reason to grant the petition for certiorari.

STATEMENT OF THE CASE

I. Factual Background.

In April 1997, one year after Jewell began working for Sprint Telecommunications Venture, he claimed that he was unable to work and sought disability benefits. Jewell described himself as "[d]epressed" and stated that he had been treated for depression for a number of years. Pet. App. 2a-3a. LINA, which underwrote and administered the benefits plan, investigated Jewell's claim. The available medical information, including an independent medical examination that LINA requested, confirmed a diagnosis of depression and anxiety. LINA approved short-term and, later, long-term disability benefits. *Id.* at 3a. LINA advised Jewell that it was paying long-term disability benefits subject to the plan's mental illness provision, which limited such benefits to 24 months' duration if mental illness caused or contributed to the disability. *Id.*

Before his long-term benefits would have expired under the mental illness limitation, LINA invited Jewell to provide any additional information demonstrating that his condition was caused solely by an "organic" (i.e., physical) disability. Jewell replied that he had no other information to submit. He did not challenge application of the mental illness limitation at any time during the 24 months he

received long-term benefits, from October 1998 through October 2000, or during the next two years. *Id.*

Jewell requested reconsideration of LINA's benefits determination in August 2002, "around the time his wife abandoned him" and withdrew her financial support, and a few months after his involvement in a serious motorcycle accident. *Id.*; Appellant's 10th Cir. Opening Br. at 26 (citing Tenth Circuit Appendix ("10th App.") 178). For the first time in over four years, he claimed that his original disability was caused by an organic brain injury, not mental illness (including depression). Pet. App. 3a. Thus, he sought retroactive reinstatement of long-term benefits, unconstrained by the 24-month mental illness limitation. To obtain such benefits under the plan, Jewell was required to establish not only that mental illness did not contribute to his disability, but also that his alleged organic injury arose some time prior to October 2000, when his coverage expired.

After reviewing Jewell's reconsideration request, including the additional medical information he provided, LINA declined to authorize further benefits. LINA noted that Jewell's own treating physicians and mental health professionals continued uniformly to conclude that mental illness had caused or contributed to his disability, and that there was no medical evidence of an organic brain injury, much less one that existed prior to October 2000. Nevertheless, LINA invited Jewell to provide any other available medical documentation. Nine months later, Jewell submitted a second appeal

along with limited additional information. *Id.* Based on all the medical reports and other records before it, LINA again concluded that Jewell's inability to work stemmed from mental illness, not an organic brain injury. *Id.* Jewell then filed suit.

II. Proceedings Below.

After removal of Jewell's state court action to federal court, the case proceeded as a claim under Section 1132(a)(1)(B). Pet. App. 4a. The Sprint plan did not grant LINA discretion to determine eligibility for benefits, and LINA therefore acknowledged that its benefits determination was subject to de novo review under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

After discovery, LINA moved for judgment on the record developed during its extensive claims administration process. Pet. App. 4a. Jewell did not object to this procedure, but he did ask permission to "augment the record" with expert testimony under the guidelines set forth in *Hall v. UNUM Life Insurance Co. of America*, 300 F.3d 1197 (10th Cir. 2002). Pet. App. 4a; *see also* 10th App. 586 ("[D]iscovery should be completed and Plaintiff [should be] allowed to supplement the record pursuant to *Hall* prior to the ruling on this matter."). *Hall* gives district courts discretion to supplement the administrative record when such supplementation is necessary to conduct an adequate de novo review under Section 1132(a)(1)(B). 300 F.3d at 1202-03.

The district court reserved ruling on Jewell's request to supplement the record, pending Jewell's

submission of affidavits outlining the additional evidence he sought to introduce. Pet. App. 4a. Jewell later provided (as relevant here) letters from two physicians and his own affidavit. LINA objected to the new evidence as not meeting the *Hall* standards. In a December 2005 order, the district court decided to admit the evidence, and set a hearing to decide LINA's motion for judgment. The order stated that there would "not be an evidentiary hearing" and that the court's review would be "limited to the parties' briefs, the attorneys' arguments, and the administrative record and supplements thereto which the Court has allowed in this Order." 10th App. 787-88.

Jewell did not object to or request reconsideration of the December 2005 order; nor did he request an evidentiary hearing or trial. Rather, Jewell agreed that *Hall* would control the district court's decision on whether to supplement the record, and he did not proffer evidence beyond the already accepted letters and affidavit. After argument in March 2006, the district court concluded that Jewell was entitled to long-term disability benefits, based almost exclusively on the two supplementary doctors' letters, which the court treated as unrebutted expert testimony. Pet. App. 5a.

LINA appealed, arguing that under *Hall* the district court's consideration of Jewell's extra-record evidence was an abuse of discretion, and that even the new evidence confirmed the applicability of the mental health limit. In response, Jewell contended that the district court properly exercised its discretion under *Hall*. Jewell never contended that

Hall stated too narrow a rule for admission of evidence; nor did he suggest that the district court should have applied any other standard of admissibility, much less that the Due Process Clause required a broader standard.

In a unanimous opinion authored by Judge McConnell, the Tenth Circuit applied *Hall* – as all parties had agreed that it should – and concluded that the district court had abused its discretion in allowing Jewell to supplement the record. *Id.* at 1a-29a. At the outset, the court confirmed the important policy reasons, as previously outlined in *Hall*, for limiting de novo review to the administrative record except where circumstances warrant presentation of additional evidence. Such a limitation prevents federal courts from functioning as "substitute plan administrators"; "encourage[s] the parties to develop the factual record as fully and as early as possible"; "may avert problems related to the loss or staleness of evidence"; "makes it easier for the plan administrator to come to an objectively correct, well-supported determination"; and "decreases both the likelihood of subsequent federal litigation and the costs that would be attendant thereto." *Id.* at 6a-7a. Ultimately, the Tenth Circuit recognized that "a fully developed administrative record facilitates 'the goal of prompt resolution of claims by the fiduciary under the ERISA scheme,'" and "if litigation should ensue, . . . deters the practice of holding back evidence for presentation to the district court as a fallback or a 'surprise.'" *Id.* at 7a-8a (citation omitted).

Against this backdrop, the court of appeals concluded that under *Hall* the district court should not have accepted and considered Jewell's post hoc submissions. Those submissions provided no assistance in resolving any medical complexities or credibility issues; the information could have been provided earlier, when LINA made its benefits determination or during the administrative appeal process; and large portions of the letters were cumulative of documentation already before the plan administrator. *Id.* at 15a-27a. Therefore, the court remanded the case to the district court for a determination on the merits, based on a de novo review of the unsupplemented administrative record. *Id.* at 28a-29a.

REASONS FOR DENYING THE PETITION

Contrary to Jewell's contention, this case does not present the issue raised in his petition, i.e., whether "a civil action authorized by ERISA § 502(a)(1)(B) is a plenary proceeding governed by the Federal Rules of Civil Procedure or limited to a review of a claim record as a court would decide an administrative law claim." Pet. 4. And even if it did, there is nothing in the Tenth Circuit's decision – which is consistent with the decisions of other Circuits, as well as with this Court's precedent and with ERISA itself – that merits this Court's review.

Indeed, most of Jewell's arguments reflect a fundamental confusion between two distinct issues: the appropriate standard of review in a Section 1132(a)(1)(B) case, and the scope of the record to be considered in applying that standard of review. The

former question is not at issue in this case. All parties have agreed, and the Tenth Circuit properly held, that – pursuant to this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) – the standard of review of the plan administrator's decision is de novo. But the question of whether de novo review should be carried out on a closed record (as is the case with, for instance, court of appeals review of a district court's summary judgment decision), or on a record that has been partially or fully opened for submission of further evidence, is an entirely separate one. As to that latter question, the Tenth Circuit's approach, which in Section 1132(a)(1)(B) cases involving de novo review affords the trial court discretion to add to the record that was before the plan administrator, is wholly unexceptional.

I. The Question Presented In The Petition Was Not Raised Or Passed On Below, And Is In Any Event Not Squarely Presented On Interlocutory Review.

1. Certiorari should be denied because Jewell asks this Court to review a question he did not raise, and that was not passed upon, below. *See Duignan v. United States*, 274 U.S. 195, 200 (1927); *see also, e.g., Cooper Indus., Inc. v. Aviall Servs., Inc.*, 543 U.S. 157, 169-70 (2004); *United States v. Ortiz*, 422 U.S. 891, 898 (1975); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970).

On appeal, Jewell argued only that the district court properly applied the Tenth Circuit's decision in *Hall v. UNUM Life Insurance Co. of America*, 300

F.3d 1197 (10th Cir. 2002) – a case he does not mention in his petition – and did not abuse its discretion in supplementing the administrative record. Jewell acknowledged below that *Hall* "sets out circumstances where the trial court may admit additional evidence that would be of assistance in the de novo review of the benefits decision," and contended that "the district court followed the guidelines set forth in *Hall*." Appellee's 10th Cir. Answer Br. and Opening Cross-Appeal Br. at 14; *see also id.* at 15, 23-34.

Jewell never raised any of the arguments contained in his petition. He did not contend that *Hall* was inapplicable, or wrongly decided because it set forth too restrictive a standard for admitting evidence in de novo review proceedings. He did not suggest that he was entitled to consideration of his supplemental evidence, or to some broader "plenary proceeding," without regard to the guidelines that *Hall* established. And he did not contend that Section 1132(a)(1)(B) of ERISA, this Court's decisions, or due process principles independently mandated affirmance of the district court's decision to admit the supplemental evidence.

Because Jewell did not question *Hall*, the Tenth Circuit did not address whether Section 1132(a)(1)(B) claimants are always entitled to a plenary proceeding in which they can introduce evidence that was not before the plan administrator. Instead, the Tenth Circuit straightforwardly applied *Hall* to the facts of this case. Its decision hardly stands for the proposition that review is always limited to the plan administrator's record, or that

review is to be conducted as if the case involved review of an administrative agency's decision, as Jewell suggests. Pet. 4, 8. On the contrary, after a detailed review of Jewell's tendered extra-record documents, the Tenth Circuit held only that on the facts of this particular case, the admission of the new evidence was not warranted. Pet. App. 10a-27a. The court made clear that district courts must make such discretionary determinations on a case-by-case basis. *Id.* at 8a-10a. And the Tenth Circuit remanded for de novo review of the plan administrator's determination based on the evidence that was before the administrator.[1]

2. This waiver is sufficient reason to deny the petition. But Jewell's challenge is not squarely presented in any event. Given the Tenth Circuit's disposition of the appeal, it remains to be seen whether the admission of supplemental evidence would make any difference to the outcome of Jewell's case. When the district court conducts its de novo review on remand, it may find (although, in LINA's view, it should not) that the record that was before the plan administrator shows that Jewell is entitled to the further benefits he seeks. Thus, "because the Court of Appeals remanded the case, it is not yet ripe for review by this Court." *Brotherhood of Locomotive Firemen & Enginemen v. Bangor & Aroostook R. Co.*, 389 U.S. 327, 327-28 (1967); *see also, e.g., Hamilton-*

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[1] Notably, Jewell did not seek panel rehearing or rehearing en banc, even though the en banc court would have had the power to overrule the prior panel decision in *Hall*. *See Burlington N. & Santa Fe Ry. Co. v. Burton*, 270 F.3d 942, 947 (10th Cir. 2001).

Brown Shoe Co. v. Wolf Bros. & Co., 240 U.S. 251, 258 (1916) ("[E]xcept in extraordinary cases, the writ is not issued until final decree.").

II. There Is No Circuit Split Justifying This Court's Review.

In all events, the purported circuit conflict identified in Jewell's petition does not exist.

According to Jewell, the decision below is in "direct conflict" with the approach taken by the Seventh Circuit – a proposition for which Jewell cites *Diaz v. Prudential Insurance Co.*, 499 F.3d 640 (7th Cir. 2007). Pet. 8. That argument is misleading at best. *Diaz* does not address the question of the proper scope of the record on de novo review in a Section 1132(a)(1)(B) case. It merely explains that no deference is due a plan administrator's judgment in a case applying the de novo standard. *See* 499 F.3d at 643. But the Seventh Circuit has made crystal clear – in a decision cited in *Diaz* – that it takes exactly the same approach as the Tenth Circuit with respect to the scope of the record in such cases.

In *Patton v. MFS/Sun Life Financial Distributors, Inc.*, 480 F.3d 478 (7th Cir. 2007), *cited in Diaz*, 499 F.3d at 643, the court of appeals held that in conducting de novo review "the district court had discretion to limit the evidence to the record before the plan administrator, or . . . [to] permit the introduction of additional evidence necessary to enable it to make an informed and independent judgment," and reviewed the district court's exclusion of additional evidence for abuse of discretion. 480 F.3d at 490 (internal quotation

marks omitted); *see also Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994). The Seventh Circuit specifically noted that it was applying the *same standard* that the Tenth Circuit applied in *Hall* – which is, of course, the very standard applied in the decision at issue here. 480 F.3d at 491. In light of *Patton*, Jewell's claim of a conflict with the Seventh Circuit is mystifying.

Jewell's claim of a conflict with the Eleventh Circuit, for which he relies on *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), is similarly misplaced. In *Moon*, the court stated in passing that "American Home's contention that a court conducting a de novo review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a de novo review." *Id.* at 89. But the court did not address whether a party is entitled to a "plenary proceeding" in connection with a de novo review of a benefits determination, as Jewell claims he is, or under what circumstances a district court should consider evidence beyond what is contained in the administrator's record. Moreover, the dispute in *Moon* did not relate to the existence of a disability at a particular point in time; it related to whether the claimant's decedent was indeed an "officer" of his company and whether he had in fact been traveling on business when he was killed in a plane crash. *Id.* at 87. That type of "extrinsic matter" may not be found in a plan administrator's record, *see Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 519-20 (1st Cir. 2005), and therefore might

well be properly admitted by a district court exercising the kind of discretion that *Hall* affords.

Even if *Moon* were in some tension with the Tenth Circuit's decision (and it is not), it is not indicative of any widespread problem. Every other court of appeals to have addressed the issue – all subsequent to the 1989 decision in *Moon* – has taken an approach that is fully consistent with the Tenth Circuit's. *See, e.g., Orndorf*, 404 F.3d at 519-20 ("[T]he fact that judicial review is de novo does not itself entitle a claimant to a trial or to put on new evidence. . . . The focus of the review under de novo review is still the administrator's decision and must ordinarily be based on the administrative record. There may be times when it is appropriate for courts to hear new evidence."); *Krizek v. Cigna Group Ins.*, 345 F.3d 91, 98 (2d Cir. 2003) (court should not exercise its discretion to allow supplemental evidence unless claimant can demonstrate good cause); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1184-85 (3d Cir. 1991) (noting that "[i]f the record on review is sufficiently developed, the district court may, in its discretion, merely conduct a de novo review of the record of the administrator's decision"); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1025 (4th Cir. 1993) ("The district court should exercise its discretion [to receive additional evidence] only when circumstances clearly establish that additional evidence is necessary to conduct an adequate review of the benefit decision."); *Brown v. Seitz Foods, Inc.*, 140 F.3d 1198, 1200 (8th Cir. 1998) (discouraging admission of supplemental evidence in order to

"ensure expeditious judicial review of ERISA benefit decisions and to keep district courts from becoming substitute plan administrators," but allowing such evidence where necessary for adequate de novo review (internal quotation marks omitted)).[2]

Accordingly, there is no circuit conflict justifying review. Any relevant disagreement between the Eleventh Circuit and the Tenth is "more apparent than real," *Bunting v. Mellen*, 541 U.S. 1019, 1021-22 (2004) – and the Eleventh Circuit decision is nothing more than an aging outlier. This Court should therefore deny the petition, as it has previously done in cases alleging the same conflict that Jewell has alleged here. *See, e.g., Orndorf v. Paul Revere Life Ins. Co.*, 546 U.S. 937 (U.S. Oct 11, 2005) (No. 05-189).

III. The Decision Below Is Fully Consistent With ERISA And This Court's Precedent.

The Tenth Circuit's *Hall* rule is consistent with ERISA's framework and animating policies, as well as with this Court's ERISA precedents. Although

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[2] *See also, e.g., Vega v. Nat'l Life Ins. Servs. Inc.*, 188 F.3d 287, 299 (5th Cir. 1999) (when conducting de novo review, the district court is generally "constrained to the evidence before the plan administrator" with certain exceptions, such as evidence related to interpreting the plan or explaining medical terms and procedures); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (holding that, with certain exceptions, "the de novo review required by *[Firestone v.] Bruch* is a de novo review of the record before the administrator"); *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995) (holding that supplemental evidence is admissible if necessary to conduct an adequate de novo review).

Jewell contends that a plenary proceeding is required here because federal-court review is de novo and takes place in the context of a "civil action," 29 U.S.C. § 1132, these arguments founder on the well-established principle that the scope of proper evidentiary consideration is a function of congressional purpose regarding the statute at issue.

The *Hall* rule is a sensible implementation of ERISA, which makes plan administrators the primary arbiters of employee benefits claims, and then provides an avenue by which employees may obtain judicial review of benefits determinations. *See generally* 29 U.S.C. §§ 1132, 1133. The statute ensures that federal courts have a record on which to review benefits determinations by requiring plan administrators to provide employees a "reasonable opportunity" to argue their entitlement to benefits, "a full and fair review by the appropriate named fiduciary of the decision denying the claim" based on any relevant evidence the employee wishes to submit, and adequate notice of the reasons for claim denial. *Id.* § 1133; *see also* 29 C.F.R. § 2560.503-1(b).

Employees denied benefits can then file suit in order to obtain federal court review of the administrator's decision. 29 U.S.C. § 1132(a)(1)(B); *Firestone*, 489 U.S. at 105; *see also, e.g., id.* at 108, 109, 115. *Firestone* makes clear that courts considering actions under Section 1132(a)(1)(B) do not write on a blank slate: they are reviewing a plan administrator's decision, either under a de novo or an arbitrary and capricious standard of review. *See id.* at 115.

Because ERISA itself does not expressly define what evidence district courts may consider when they review a plan administrator's decision de novo, the courts may determine that question – like the standard of review – in light of congressional purposes. *See id.* at 110 (developing standard of review as matter of federal common law after examining congressional purposes). *Firestone* did not explicitly address the scope-of-evidence question. In *Hall*, the Tenth Circuit held that "the best way to implement ERISA's purposes . . . is to allow the district court to supplement [the administrative] record when . . . additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." 300 F.3d at 1202 (internal quotation marks omitted). That rule is consistent with ERISA's framework: it recognizes that the employee has had the opportunity to enter favorable evidence into the record during the primary claim proceeding before the plan administrator, but allows the district court to admit new evidence in order to ensure meaningful and effective review.

The rule is also consistent with the congressional purposes behind the ERISA statutory scheme. In addition to establishing fair benefits determination procedures, Congress's purposes included "promot[ing] the interests of employees and their beneficiaries in employee benefit plans," *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983), while containing litigation expenses and administrative costs, *see Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). The *Hall* rule helps keep litigation costs down by "promot[ing] the internal resolution of

claims": employees will be more likely to present all of their evidence to administrators, allowing a more accurate and final determination, if they know that the reviewing court will not necessarily permit new evidence. *Quesinberry*, 987 F.2d at 1022 (internal quotation marks omitted); *see also* Pet. App. 7a-8a. Fostering the plan administrators' ability to be the primary decisionmakers furthers "prompt and fair claims settlement," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), and prevents the federal courts from becoming overburdened as "substitute plan administrators," *Quesinberry*, 987 F.2d at 1025; *see also Perry*, 900 F.2d at 966. In sum, the *Hall* rule is consistent with ERISA and with relevant Supreme Court precedent.[3]

Jewell's contrary arguments are misplaced. First, Jewell blurs the distinction between the standard of review and the rules regarding what evidence the court may consider as part of that review. But de novo review need not go hand-in-hand with plenary evidentiary consideration. *See United States v. Raddatz*, 447 U.S. 667, 673-74 (1980) (distinguishing between de novo review of the record below and a de novo *hearing* that would involve new evidence). Indeed, in construing other statutes providing for de novo review, this Court has looked to congressional intent and concluded that de novo review would

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[3] This Court's long-standing recognition that ERISA is intended to promote more streamlined benefits procedures defeats Jewell's argument that the only evidence of congressional intent to this effect comes from a Senate Report pertaining to an earlier version of the statute. *See* Pet. 16-17.

entail judicial discretion to admit new evidence, but no obligation to do so. *See, e.g., id.*

Because a de novo standard of review does not mandate a plenary proceeding, the cases on which Jewell relies that concern the standard of review of an administrative decision are inapposite. For instance, *United States v. First City National Bank*, 386 U.S. 361 (1967), *quoted in* Pet. 12, did not address the scope of the evidentiary record. Instead, the Court analyzed the *standard of review* under the Bank Merger Act of 1966, which stated that the "issues presented" were to be examined "de novo." 386 U.S. at 368. Although Jewell relies on the Court's remark that deference to an agency's determination was inappropriate, that passage concerned only the difficulty of deferring to the agency in the absence of any administrative record. *See id.*

Second, Jewell contends that because Section 1132(a)(1)(B) authorizes employees whose benefits have been denied to file a "civil action" to "recover benefits due," he must be entitled to a plenary proceeding. That argument is also mistaken. The label "civil action" does not automatically guarantee a right to present new evidence. Numerous statutes grant the right to file a "civil action" to review an administrative decision, while limiting the proceeding to review of a record or committing the scope of evidence to the court's discretion. *See, e.g.*, 47 U.S.C. § 332(c)(7)(B) (allowing civil "action" to be filed in district court, but providing for "substantial evidence" review on a "written record"); *Roxanne J. v. Nevada County Human Servs. Agency*, 2006 WL

3437494 (E.D. Cal. 2006) (Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 *et seq.*, permits "civil action" to review administrative determination, and allows introduction of some new evidence). Thus, the scope of the evidentiary record in a "civil action" is simply a function of congressional policies with respect to the statutory scheme at issue – and, as noted above, the *Hall* common-law rule implements this Court's established understanding of ERISA's purposes.[4]

The cases Jewell cites in support of his argument that a "civil action" must include an opportunity to present new evidence are irrelevant, as they concern statutes other than ERISA. Jewell primarily relies on *Chandler v. Roudebush*, 425 U.S. 840 (1976), in which the Court held that federal employees are entitled to a plenary trial under Title VII. Although the review mechanism was, like here, a "civil action," the Court's holding was based on the fact that, unlike Section 1132(a)(1)(B), Title VII expressly contemplates a *trial* proceeding. *Chandler*, 425 U.S. at 845 (quoting Title VII's requirement that the action be expeditiously scheduled "for trial"). Beyond the statutory language, the legislative history of Title VII "confirms that Congress intended to accord

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[4] For this reason, Jewell's related argument that the Tenth Circuit decision contemplates a procedure "outside the bounds of the Federal Rules of Civil Procedure," Pet. 15, is also meritless. *See, e.g., Capistrano Unified School Dist. v. Wartenberg By and Through Wartenberg*, 59 F.3d 884, 892 (9th Cir. 1995) (de novo review with discretionary admission of new evidence was "what Congress intended under [IDEA] . . . even though it does not fit well into any pigeonhole of the Federal Rules of Civil Procedure").

federal employees the same right to a trial de novo as is enjoyed by private-sector employees." *Id.* at 848. There is no comparable evidence of congressional intent with respect to Section 1132(a)(1)(B).[5]

Similarly, Jewell's reliance on the jury trial required by *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558 (1990), misses the mark, because that case concerned a federal common law breach-of-representation claim under Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"). Aside from the fact that the action challenged the union's conduct rather than seeking review of its determinations, this Court has specifically eschewed "the *wholesale* importation" of LMRA standards into ERISA. *Firestone*, 489 U.S. at 109 (emphasis in original).

IV. The Decision Below Is Fully Consistent With Due Process Principles.

Jewell next argues that due process principles require that employees be entitled to introduce new evidence at will in de novo actions under Section 1132(a)(1)(B). All of his contentions founder on the fact that ERISA and its regulations provide extensive procedural protections that govern the

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[5] Jewell makes too much of a footnote in *Chandler* regarding indications of Congress's intention to confine review to the administrative record. 425 U.S. at 862 n.37, *quoted in* Pet. 11-12. Even if such a clear-statement rule existed, it would have little application where, as here, Congress has left many aspects of the civil action – even the standard of review – to be developed by courts as a matter of federal common law. *See Firestone*, 489 U.S. at 110; *King v. Hartford Life & Acc. Ins. Co.*, 414 F.3d 994, 998 (8th Cir. 2005).

plan administrator's benefits determination. Moreover, to the extent that an employee is denied the opportunity to present material evidence to the plan administrator, the *Hall* rule affords district courts discretion to consider such evidence.

As noted above, Section 1133 requires that plan administrators afford employees a "full and fair review" of benefits claims. The implementing regulations more specifically require, *inter alia*, (1) an explanation of the reasons supporting a denial of benefits, including a list of any necessary additional material; (2) an opportunity to submit a range of documentary evidence on appeal to the plan administrator; and (3) a "review that takes into account all comments, documents, records, and other information submitted by the claimant." 29 C.F.R. § 2560.503-1(f)(3), (h)(2); *see also id.* § 2560.503-1(a), (e)-(g) (1998) (amended).

Jewell suggests that these procedures are insufficient because they do not provide for "an evidentiary hearing or discovery proceedings." Pet. at 17; *see also id.* at 20. But to the extent that the procedures do not operate fairly in any particular case, the Tenth Circuit's rule gives the district court discretion to consider new evidence. Pet. App. at 8a. This alleviates any due process concerns that might otherwise arise.[6] *See Raddatz*, 447 U.S. at 680-81

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[6] For the same reason, Jewell's suggestion that plenary proceedings are required by *Firestone*'s statement that ERISA was intended to preserve pre-ERISA common-law protections, Pet. 14, is off the mark. Regardless of whether Jewell could have received a full trial pre-ERISA, there is no question that

(rejecting due process challenge to review scheme, in part because the reviewing court has the discretion to receive additional evidence as part of its de novo review).

Moreover, Jewell's attack proves too much, as his argument, if accepted, suggests that *Firestone* was wrongly decided. *Firestone* held that the standard of review varies according to plan terms: an employer can obtain the arbitrary and capricious standard by conferring discretionary authority on the plan administrator. 489 U.S. at 112, 115. Given that the standard of review may often be outcome-determinative, the Court's willingness to countenance such differing standards indicates its confidence that all employees will have an adequate opportunity to present their evidence at the administrative stage. *See id.* at 113.

In addition, the arbitrariness review contemplated by *Firestone* is, by its nature, performed purely on the administrator's existing record. *See, e.g., Liston v. UNUM Corp. Officer Severance Plan*, 330 F.3d 19, 23-24 (1st Cir. 2003) (a closed record "is almost inherent in the idea of reviewing agency or other administrative action for reasonableness"). Since *Firestone* itself anticipates that courts will review some benefits determinations on a closed record, it is hard to see how due process could require that plaintiffs in de novo actions be permitted to supplement the administrative record as of right. *See also, e.g., Sandoval v. Aetna Life &*

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the current framework affords claimants fully adequate evidentiary opportunities.

Cas. Ins. Co., 967 F.2d 377, 380-31 (10th Cir. 1992); *Perry*, 900 F.2d at 967; *Voliva v. Seafarers Pension Plan*, 858 F.2d 195, 196 (4th Cir. 1988).

The authorities on which Jewell relies do not suggest a contrary conclusion. For instance, *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971), *cited in* Pet. 21-22, supports denying, not granting, the petition. There, the Court remanded the case for review "based on the full administrative record that was before the Secretary." 401 U.S. at 420. As under the Tenth Circuit's decisions in *Hall* and in this case, *Volpe* accorded the district court discretion to decide whether hearing additional testimony would be necessary for "effective judicial review." *Id.*[7]

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

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[7] The other authorities Jewell cites are similarly unhelpful to his cause. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985), and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), *cited in* Pet. 17-18, do not address, even implicitly, whether Section 1132(a)(1)(B) entitles claimants to a plenary proceeding, or the scope of review under that provision. *See* 473 U.S. at 148; 536 U.S. at 359. And *Ramsey v. Hercules, Inc.*, 77 F.3d 199 (7th Cir. 1996), and *Herzberger v. Standard Insurance Co.*, 205 F.3d 327 (7th Cir. 2000), *cited in* Pet. 19-20, express concerns about applying *deferential* review – concerns that are not apposite in this de novo review case.

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Supreme Court of the United States

LYNN JEWELL,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER'S PETITION FOR A WRIT OF CERTIORARI

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IN THE

Supreme Court of the United States

No. 07-1121

LYNN JEWELL,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER'S PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF STANDING

Pursuant to Rule 37, a blanket letter of consent from the parties to this appeal has been filed with the Clerk of the Court permitting this brief on behalf of *amicus*.[1]

[1] Pursuant to Rule 37.6, no counsel for either party has authored this brief in whole or in part and no person or entity has made a monetary contribution to the preparation or submission of this brief.

This *Amicus* brief is submitted by Eugene R. Anderson, a member of the Bar of this Court, on behalf of United Policyholders.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

United Policyholders, ("UP") is a not-for-profit corporation founded in 1991 as an educational resource for the public on insurance issues and insurance consumer rights. The organization is tax-exempt under Internal Revenue Code § 501(c) (3). UP is based in California but operates nationwide and is funded by donations and grants from individuals, businesses, and foundations and governed by an eight-member Board of Directors. UP contributes on an ongoing basis to the formulation of insurance related public policy at both the national and state level.

UP exists because businesses and individuals rely on the insurance they buy to protect themselves, their property and their livelihoods against the risk of loss and insurance companies are in business to earn profits by assuming that risk. Insurance is a regulated industry because of this dynamic and the fact that the financial security insurance policies provide is an integral part of the fabric of our society and economy.

UP monitors the insurance sector, works with public officials, has a nationwide network of volunteers and affiliate organizations, publishes written materials, files *amicus* briefs in cases involving coverage and claim disputes and is a general information clearinghouse on consumer issues related to commercial and personal lines insurance products. UP

provides disaster aid to property owners across the U.S. via educational activities designed to illuminate and demystify the claim process. For more information about UP, please visit www.unitedpolicyholders.org.

In this brief, United Policyholders seeks to fulfill the "classic role of *amicus curiae* by assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention to law that escaped consideration." *Miller-Wohl Co. v. Commissioner of Labor & Indus.*, 694 F.2d 203, 204 (9th Cir. 1982). This is an appropriate role for *amicus curiae*. As commentators have often stressed, an *amicus* is often in a superior position to "focus the court's attention on the broad implications of various possible rulings." R. Stern, E. Greggman & S. Shapiro, *Supreme Court Practice*, 570-71 (1986) (*quoting* Ennis, *Effective Amicus Briefs*, 33 Cath. U.L. Rev. 603, 608 (1984)).

United Policyholders has filed over one hundred and thirty five *amicus* briefs since it was founded. UP's *amicus* brief was cited in the U.S. Supreme Court's opinion in *Humana Inc. v. Mary Forsyth*, 525 U.S. 299 (1999). UP was the only national consumer organization to submit an *amicus* brief in the landmark case of *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003). Arguments from our *amicus curiae* brief were cited with approval by the California Supreme Court in *Vandenberg v. Superior Court*, 982 P.2d 229 (Cal. 1999), and discussed in *Julian v. Hartford Underwriters Ins. Co.*, 110 P.3d 903 (Cal. 2005). UP's *amicus* brief factored into the decision in *Watts Industries, Inc. v. Zurich American Ins. Co.*, 121 Cal. App. 4th 1029 (2d Dist. 2004).

United Policyholders respectfully suggests that this Court grant the Petitioner, Lynn Jewell's, petition and in support says:

POINT I.

This case does not involve the issues that normally concern this Court.

While not compelling, this case is about the denial of benefits to a disabled individual. See article in the magazine section of the Sunday New York Times, March 16, 2008 by Jeffrey Rosen entitled "Supreme Court Inc.", p. 38.

POINT II.

This case involves a split among the circuits.

United Policyholders respectfully submits that it anticipates that this point will be fully briefed by the Petitioner.

POINT III.

This case and the Cases that Reach Similar Conclusions are Against Weighty and Thoughtful Academic and Scholarly Authority.

Yale Law School Professor John H. Langbein has seen the issue here and has written a scholarly article on the subject. *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, Spring 2007. *See, also* Jay Conison, *Suits for Benefits Under ERISA*, 54 U. Pitt. L. Rev. 1 (Fall 1992) and Professor Peter Phillips and Bridget Thornton, *Practices in Health Care and Disability Insurance: Delay, Diminish, Deny, and Blame*, which was

published on-line at http://www.justhealthnow.org/Projects/Practices-in-Health-Care-and-Disability-Insurance-Delay-Diminish-Deny-and-Blame.html.

Respectfully submitted,

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